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ARMY HEALTH CARE

Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed

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April 2009

ARMY HEALTH CARE

Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed

GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-09-357, a report to congressional requesters

Why GAO Did This Study

In February 2007, a series of *Washington Post* articles disclosed problems at Walter Reed Army Medical Center, particularly with the management of servicemembers receiving outpatient care. In response, the Army established Warrior Transition Units (WTU) for servicemembers requiring complex case management. Each servicemember in a WTU is assigned to a Triad of Care—a primary care manager, a nurse case manager, and a squad leader—who provide case management services to ensure continuity of care. The Army established staff-to-servicemember ratios for each Triad of Care position. This report examines (1) the Army's ongoing efforts to staff WTU Triad of Care positions and (2) how the Army monitors the recovery process of WTU servicemembers. GAO reviewed WTU policies, analyzed Army staffing and monitoring data, interviewed Army officials, and visited five selected WTUs.

What GAO Recommends

GAO recommends that the Army (1) examine the staffing model of the Walter Reed WTU, (2) expedite efforts to implement policy related to servicemembers' transition plans, and (3) ensure that the results from its WTU satisfaction survey are representative of all servicemembers in WTUs. While DOD concurred with GAO's recommendations, its comments on actions planned and taken did not fully address recommendations on the Walter Reed staffing model and the WTU satisfaction survey.

To view the full product, including the scope and methodology, click on GAO-09-357. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

The Army has taken several steps to help ensure that WTUs are staffed appropriately. First, the Army developed policies aimed at reducing WTU staffing shortfalls, including a policy requiring the reassignment of other personnel on an installation to fill open WTU positions. Second, in October 2008, the Army revised its WTU staffing model, including the staff-to-servicemember ratios for two of its Triad of Care positions, because an Army study determined that the existing ratios were not adequate to provide an appropriate level of care to servicemembers in WTUs. The Army has made considerable progress in meeting the new ratios, and as of January 2009, the Triad of Care positions at most WTUs were fully staffed. However, staffing ratios for the WTU at Walter Reed Army Medical Center were not revised, even though the Army recognizes that servicemembers treated at this facility have more complex health care needs than servicemembers at other WTUs. Walter Reed might require a different staffing model, for example, one that decreases the number of servicemembers assigned to staff members, but the Army does not plan to conduct an assessment of Walter Reed's staffing model. Third, the Army modified its WTU placement and exit criteria for full-time servicemembers, excluding Army Reserve and National Guard servicemembers who comprise about one-third of the WTU population. These changes are intended to help ensure that only those who need complex case management are in WTUs. Those with less serious health care needs can be reassigned to other units on the installation to continue their recovery. As the Army expected, the WTU population of full-time servicemembers declined by about 1,500 in the 4 months after implementation of the new criteria.

To monitor the recovery process of WTU servicemembers, the Army has implemented transition plans for individual servicemembers as well as various upward feedback mechanisms to identify concerns and gauge satisfaction. In January 2008, the Army issued a policy establishing Comprehensive Transition Plans, which can be used to monitor and coordinate servicemembers' care. To help ensure consistent implementation of these plans among its WTUs, the Army is developing a new policy that includes the systematic collection of performance measures across WTUs. However, despite Army officials' repeated assurances to GAO that this policy was forthcoming, it had not been finalized as of February 27, 2009. The Army's feedback mechanisms include its Warrior Transition Unit Program Satisfaction Survey, which collects information from servicemembers in WTUs on a number of issues, including the primary care manager and nurse case manager. However, the survey's response rates for the WTUs have been low (13 to 35 percent) and the Army has not determined whether the results obtained from the respondents are representative of all WTU servicemembers. An Army official told GAO that the Army does not plan to conduct analyses to determine whether the survey results are representative, because it is satisfied with the response rates. In GAO's view, the response rates are too low for the Army to reliably report satisfaction of servicemembers in WTUs.

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Abbreviations

DOD	Department of Defense
MTF	military treatment facility
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
WTU	Warrior Transition Unit

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Congressional Requesters

Approximately 24,000 Army servicemembers have been wounded in action in Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), as of December 2008.[1] Due to improved battlefield medicine, those who might have died in past conflicts are now surviving, many with multiple serious injuries that require extensive outpatient rehabilitation, such as amputations, burns, and traumatic brain injuries. Seriously injured servicemembers are usually transported to military treatment facilities (MTF) in the United States, with most treated at Walter Reed Army Medical Center or the National Naval Medical Center.[2] In February 2007, a series of *Washington Post* articles disclosed serious deficiencies at Walter Reed, particularly with the management of servicemembers who had been released from the hospital and were receiving care and other services as outpatients. Specifically, the articles reported that some servicemembers remained in outpatient status for months and sometimes years without a clear understanding about their plans of care or the future of their military service. Furthermore, several review groups were tasked with investigating the reported problems.[3] The groups identified, among other things, numerous problems with the Army's management of servicemembers in an outpatient status, including inadequate case management, which helps ensure continuity of care by guiding a person's care from one service, provider, or agency to another. For example, one review group found inadequate coordination of care for some patients who visited numerous therapists, specialists, and other providers and received differing treatment plans and multiple medications.

[1]The data include active component, Reserve, and National Guard servicemembers wounded in action from October 7, 2001, through December 27, 2008. OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations.

[2]Seriously injured servicemembers are also transported to Brooke Army Medical Center in San Antonio, Texas and Balboa Naval Medical Center in San Diego, California.

[3]Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Arlington, Va., April 2007); Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007); and President's Commission on Care for America's Returning Wounded Warriors, *Serve*, *Support*, *Simplify* (July 2007).

In response to the deficiencies reported by the media, the Army took several actions, most notably initiating the development of the Army Medical Action Plan in March 2007. (This plan is currently referred to as the Warrior Care & Transition Program.) The Army used this plan to implement changes in the management of outpatient care for servicemembers returning from OEF and OIF as well as for other servicemembers receiving outpatient care at Army facilities. One key component of the plan was the establishment of a new type of Army unit for servicemembers that provides complex outpatient case management services—the Warrior Transition Unit (WTU). In June 2007, the Army began implementing WTUs, and as of January 2009 the Army had established WTUs at 33 MTFs located at military installations across the United States and at 3 MTFs overseas. Each servicemember in a unit is assigned to a team of three key staff referred to as the Triad of Care—a primary care manager, a nurse case manager, and a squad leader. The primary care manager is usually a physician who provides oversight of the servicemember's medical care; the nurse case manager is a registered nurse who coordinates and monitors options and services to meet the servicemember's health care needs; and the squad leader is a noncommissioned officer who provides direct oversight of the servicemembers, ensuring they attend medical and administrative appointments. The Triad of Care is collectively responsible for providing case management services to ensure continuity of care. In order to determine the staffing levels for the Triad of Care positions, the Army established specific staff-to-servicemember ratios, basing staffing needs on the number of WTU servicemembers, which almost tripled in the first year at the 33 U.S.-based WTUs—from about 3,500 in June 2007 to about 10,300 in June 2008.

In September 2007, we reported preliminary observations on the Army's initial efforts to establish the WTUs and staff the Triad of Care positions.[4] Subsequently, in February 2008, we provided a status update on the Army's efforts to staff the Triad of Care positions in its WTUs.[5] We found that although the Army had made considerable progress implementing the

[4]GAO, *DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers*, GAO-07-1256T (Washington, D.C.: Sept. 26, 2007).

[5]GAO, *DOD and VA: Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers*, GAO-08-514T (Washington, D.C.: Feb. 27, 2008).

WTUs, about a third of the units had less than 90 percent of staff needed to meet the staff-to-servicemember ratios that the Army had established for the Triad of Care positions. We also noted that an emerging challenge for the Army was gathering reliable and objective data to monitor the performance of WTUs and to determine how well the units were meeting servicemembers' recovery needs. This report updates our previous work and focuses on the progress that the Army has made in implementing the WTUs. Specifically, for this report, we examined (1) the Army's ongoing efforts related to staffing WTU Triad of Care positions and (2) how the Army is monitoring the recovery process of servicemembers in WTUs.

To conduct our work, we obtained documentation from and interviewed officials with the Army's Office of the Surgeon General, Medical Command,[6] Warrior Care and Transition Office,[7] Manpower Analysis Agency, and Office of the Inspector General. In addition, we visited five selected WTU locations—Forts Benning and Gordon (Georgia), Fort Lewis (Washington), Fort Sam Houston (Texas), and Walter Reed Army Medical Center (Washington, D.C.)—to obtain information from Army officials about their efforts to staff the WTUs and about their local mechanisms for monitoring servicemembers' recovery process. We selected these sites because they represent different regional Medical Commands and they vary in the number of servicemembers placed in the WTU.

To assess the Army's ongoing efforts related to staffing the WTU Triad of Care positions, we analyzed the Army's Triad of Care staffing data and WTU servicemember population data—on which staffing needs are based—for the 33 WTUs that have been established within the United States. Our analysis did not include the WTUs that have been established overseas. We also reviewed Army policies, including staff-to-servicemember ratios and WTU entry and exit criteria. We did not verify the accuracy of the Army's staffing and population data; however, we interviewed agency officials knowledgeable about the data, and we

[6]The Army's Office of the Surgeon General and Medical Command are separate entities with different duties and powers—the Office of the Surgeon General provides medical expertise to the Army and the Medical Command controls hospitals and other medical facilities. To reduce duplication and improve communication, the staff of the two entities are blended into a single staff and they report to one person, who is both the Army Surgeon General and the commander of the Army's Medical Command.

[7]The Army's Warrior Care and Transition Office is responsible for providing strategic direction and for developing and assessing plans, policies, and resources for programs dedicated to caring for wounded, ill, and injured servicemembers and their families.

determined that they were sufficiently reliable for the purposes of this report. We also did not evaluate the appropriateness of the Triad of Care ratios for meeting the staffing needs of the WTUs. To determine how the Army is monitoring the recovery process of WTU servicemembers, we reviewed Army policies, documents, and data on selected monitoring efforts that the Army has underway, including efforts to develop transition plans for individual servicemembers and to obtain feedback from servicemembers and their families. We reviewed Army data on the number of servicemembers who had been in a WTU for at least 30 days and who had transition plans as of January 6, 2009. For the Warrior Transition Unit Program Satisfaction Survey, we reviewed the Army's survey questionnaire, protocol, and results for the period July 2007 through September 2008, which were the most recently available data at the time of our review. We assessed the reliability of the transition plan and survey data by reviewing related documentation or speaking with knowledgeable agency officials and determined the data to be sufficiently reliable for our purposes.

We conducted this performance audit from June 2007 through April 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Additional information about our scope and methodology is provided in appendix I.

Background

In June 2007, the Army began establishing WTUs at United States military installations with MTFs that were providing medical care to 35 or more eligible servicemembers. As of January 2009, the Army was operating 33 of these WTUs. (See fig. 1.) The Army has also established WTUs at locations in Germany—Bavaria, Heidelberg, and Landstuhl.[8] For servicemembers with less complex medical needs, the Army uses its existing network of community-based health care organizations, which it now refers to as community-based WTUs. The community-based WTUs allow servicemembers to live at home and receive medical care while remaining on active duty.[9]

[8]Initially, most seriously injured servicemembers from OEF and OIF are evacuated to Landstuhl Regional Medical center in Germany for treatment.

[9]The community-based WTUs are located in eight states (Alabama, Arkansas, California, Florida, Illinois, Massachusetts, Utah, and Virginia) and Puerto Rico. As of December 1, 2008, the Army was serving about 1,400 servicemembers in community-based WTUs.

Figure 1: Location of WTUs at Army Installations within the United States

Source: GAO analysis of Army data.

Note: The Army also established WTUs in Germany—Bavaria, Heidelberg, and Landstuhl—and community-based WTUs in Alabama, Arkansas, California, Florida, Illinois, Massachusetts, Puerto Rico, Utah, and Virginia.

[a]The Army established a WTU at Balboa Naval Medical Center because it was sending seriously injured servicemembers to this facility for trauma care and it had a sufficient number of servicemembers to establish a WTU at this location.

A servicemember was eligible for placement in a WTU if he or she required more than 6 months of medical treatment and required complex case management. Army guidance specifies that the mission of servicemembers assigned to a WTU is to heal and transition—return to duty or to civilian life—and while WTU servicemembers may have work assignments in the unit, this work may not take precedent over the servicemembers' treatment. WTUs have a defined staffing structure that includes leadership positions of commanders and platoon sergeants, as well as administrative staff, such as human resources and financial management specialists. Within each unit, the servicemember is assigned to a team of three key staff—the Triad of Care—who provide case management services to ensure continuity of care. (See fig. 2.)

Figure 2: Description of Triad of Care Positions

Triad of Care position		Description
Primary care manager		Provides primary oversight and continuity of health care and ensures the quality of the servicemembers' care; usually a physician.
Nurse case manager		Plans, implements, coordinates, monitors, and evaluates options and services to meet the servicemembers' health care needs; a registered nurse.
Squad leader		Links the servicemember to the chain of command, builds a relationship with the servicemember, and works alongside the other parts of the Triad of Care–primary care manager and nurse case manager–to ensure the servicemember attends medical and administrative appointments and the needs of the servicemember and his or her family are met; a noncommissioned officer.

Source: GAO and Army officials.

Servicemembers in the WTUs vary by the type of medical condition for which they are receiving care and include Army active component, Reserve, and National Guard servicemembers.[10] Active component servicemembers comprise about two-thirds of the WTU population, and

[10]Active component refers to full-time active duty servicemembers. Reserve and National Guard servicemembers are called to active duty in response to a national emergency, and many were employed in civilian occupations before they were called to active duty.

active duty Reserve and National Guard servicemembers collectively comprise about one-third.[11] As of December 1, 2008, about 60 percent of servicemembers in WTUs had been wounded in combat or had incurred a noncombat injury or illness during OEF or OIF, which may have resulted in burns, amputations, or other types of conditions. The remaining servicemembers in the units included those who may have been referred to the WTU for completion of the disability evaluation process; those who incurred a noncombat injury, such as during a training exercise; and those who incurred a noncombat illness such as cancer that required complex case management.

The Army Issued Additional WTU Policies to Reduce Staffing Shortfalls, Modify Its Staffing Model, and Revise Servicemember Entry and Exit Criteria

The Army has issued additional WTU policies aimed at reducing staffing shortfalls, modifying the staffing model, and revising servicemember entry and exit criteria. To reduce staffing shortfalls, the Army issued policies designed to ensure that WTUs achieve and maintain staffing at required staff-to-servicemember ratios. The Army also implemented a revised WTU staffing model that includes new staff-to-servicemember ratios for two of the three Triad of Care positions. In addition, the Army issued policies to revise its criteria for servicemembers entering and leaving WTUs—a policy that affects population size and staffing needs.

New WTU Staffing Policies Helped Reduce WTU Triad of Care Staffing Shortfalls

Although the Army had increased the number of staff being assigned to the WTUs, staffing shortfalls continued through June 2008. When we last reported on the Army's progress in staffing the WTUs in February 2008, the Army had established a goal of having at least 90 percent of Triad of Care staff positions filled to meet the staff-to-servicemember ratios that it had established for its WTUs. These ratios were 1:200 for primary care managers; 1:18 for nurse case managers at Army medical centers that normally see servicemembers with more acute conditions and 1:36 for other types of Army medical treatment facilities; and 1:12 for squad leaders. At that time, the Army had 1,141 Triad of Care staff for its WTUs, and 11 WTUs had less than 90 percent of needed staff for one or more Triad of Care positions—representing a total shortfall of 64 staff. As of June 25, 2008, WTU Triad of Care staff had increased to 1,328, but because the size of the WTU servicemember population continued to grow and

[11]This includes all WTUs, including those in Germany and the community-based WTUs.

increase staffing needs, 21 WTUs were not meeting this goal and had staffing shortfalls in 108 Triad of Care positions. However, it is important to note that WTU staffing shortfalls represent a specific point in time. WTU staffing needs may vary daily based on both the number of servicemembers entering and exiting the WTUs and with fluctuations in the number of Triad of Care staff, who may deploy or otherwise be reassigned or leave.

To address challenges in fully staffing the WTUs, including Triad of Care positions, the Army issued new policies in July 2008 for staffing the WTUs. The Army's new policies included a requirement that local leadership—WTU commanders, MTF commanders, and senior installation commanders—fill 100 percent of WTU staff shortages, including those related to the Triad of Care, by July 14, 2008. For example, commanders were directed to fill the positions using personnel present on the installation, such as physicians and nurses who work in the MTFs, and to ensure continued 100 percent staffing from July 14, 2008, forward.

As of August 2008, after the implementation of these new staffing policies, Army data indicated that Triad of Care staffing shortfalls had been reduced considerably, and the Army had generally met its goal of 100 percent staffing of its WTUs, with only a few exceptions. As of August 25, 2008, four WTUs had staffing shortfalls in four Triad of Care positions total—Balboa was missing one nurse case manager, Fort Belvoir was missing one squad leader, and Fort Drum and Fort Irwin were each missing one primary care manager.

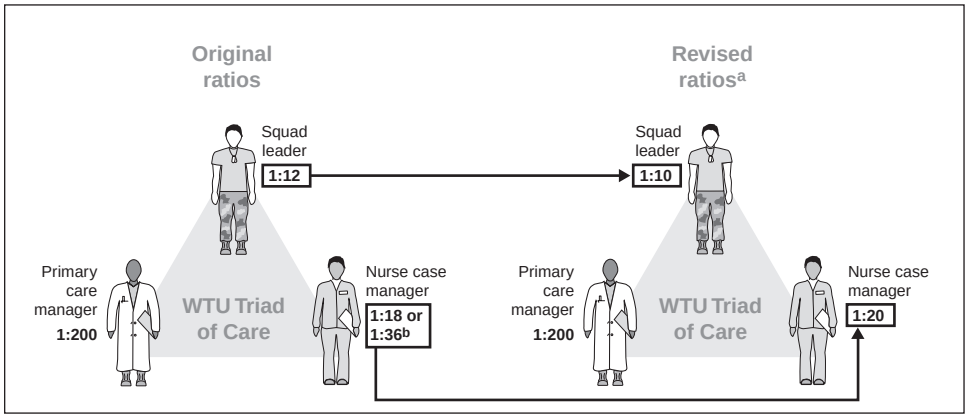
The Army Implemented a New WTU Staffing Model in Response to Study Findings, but Walter Reed Was Excluded from This Study

On October 16, 2008, the Army implemented revisions to its WTU staffing model, including changes to two of its Triad of Care staff-to-servicemember ratios. (See fig. 3.) These policy changes were based on a study initiated by the Army in February 2008 that found that some of the existing staff-to-servicemember ratios were not adequate for providing an appropriate level of care to servicemembers in WTUs.[12] The study team recommended changes to the Triad of Care staffing ratios for nurse case managers and squad leaders. The team also recommended realigning existing medical and administrative support staff in the WTU to provide

[12]The study was conducted by the United States Army Manpower Analysis Agency, a subordinate office of the Assistant Secretary of the Army's Manpower and Reserve Affairs.

direct assistance to the nurse case manager and hiring new staff to support the primary care manager.

Figure 3: Original and Revised Staff-to-Servicemember Ratios for the WTU Triad of Care



Source: GAO analysis of Army documentation.

[a]The revised ratios were the result of a study initiated by the United States Army Manpower Analysis Agency in February 2008 that found that some of the existing staff-to-servicemember ratios were not adequate for providing an appropriate level of care to servicemembers in WTUs. The revised ratios apply to all WTUs, except Walter Reed Army Medical Center, which continues to operate under its original staff-to-servicemember ratios—1:200 for primary care managers, 1:18 for nurse case managers, and 1:12 for squad leaders.

[b]The 1:18 ratio is for nurse case managers at medical centers that normally see servicemembers with more acute medical conditions. An exception is Fort Hood, which operated at a 1:25 ratio because the health care needs of its servicemember population were not as acute as for other WTUs at medical centers. Additionally, the 1:36 ratio is for nurse case managers at other types of Army MTFs.

The Army applied the revised ratios to all the WTUs except Walter Reed Army Medical Center. Army officials told us that the study team excluded Walter Reed from its review because the population receiving care at Walter Reed has more complex medical needs than the population at other WTUs. As a result, Walter Reed is continuing to operate under its original staff-to-servicemember ratios—1:200 for primary care managers, 1:18 for nurse case managers, and 1:12 for squad leaders. Despite the servicemember population at Walter Reed having more complex medical needs, these ratios are not much different than the revised ratios established for other WTUs. According to WTU officials from Walter Reed, Triad of Care staff who work with servicemembers with more complex medical needs generally require higher staff-to-servicemember ratios, but an assessment of acuity—the complexity of servicemembers' needs—is necessary for determining the exact ratios that would be appropriate for Triad of Care positions at this location. Army officials told us that the

Army currently does not have a plan for conducting a study of Walter Reed's staffing model because this facility is scheduled to close in 2011 under Base Realignment and Closure 2005.[13] According to Army officials, the WTU at Walter Reed will be moved to the newly established Walter Reed National Military Medical Center in Bethesda, Maryland. The WTU servicemember population from Walter Reed will be dispersed among the WTU at the new medical center and the WTUs at Fort Belvoir and Fort Meade.

Nonetheless, the Army had made considerable progress in meeting the new WTU staff-to-servicemember ratios for the Triad of Care positions. On January 12, 2009, 4 of the 32 WTUs in the United States (excluding Walter Reed Army Medical Center) had a total shortfall of seven Triad of Care positions—three primary care managers and four squad leaders. Walter Reed, which continued to operate under its original Triad of Care staff-to-servicemember ratios, did not have any shortfalls.

Revised WTU Servicemember Entry and Exit Criteria Have Decreased WTU Population Growth, Which Determines Staffing Needs

In July 2008, the Army also implemented policies revising WTU servicemember entry and exit criteria to increase emphasis on servicemembers needing complex case management. The revised policies stated that feedback from WTU officials, MTF commanders, and other senior officials indicated that many servicemembers in WTUs did not need the complex case management that the units provided. For example, officials from one WTU we visited told us that the WTUs included servicemembers who had conditions that were not complex, such as a broken leg, or who were waiting to finish the Army's disability evaluation process and no longer had medical appointments.[14] Army officials indicated that the growth of the WTU population—partially due to the inclusion of servicemembers who did not need complex case management—had impeded its ability to achieve and maintain staff for its Triad of Care positions in accordance with its staff-to-servicemember ratios.

[13]Base Realignment and Closure is a congressionally authorized process for the Department of Defense (DOD) to reorganize its base structure to more efficiently and effectively support forces and increase operational readiness. Base Realignment and Closure 2005 was authorized by the National Defense Authorization Act for Fiscal Year 2002, Pub. L. No. 107-107, tit. XXX, 115 Stat. 1012, 1342-53 (2001).

[14]The Army's disability evaluation process includes identifying medical conditions that could render a servicemember unfit for duty.

The Army's July 2008 policies modified WTU entry and exit criteria specifically for active component servicemembers. These revised criteria do not apply to Reserve and National Guard servicemembers, who comprise about one-third of the WTU population. Army policy indicates that Reserve and National Guard servicemembers are generally eligible for placement in a WTU if they need health care for conditions identified, incurred, or aggravated while on active duty, and they will remain in the WTU until their medical condition is resolved and they are eligible to be released from active duty or they complete the Army's disability evaluation process. According to an Army official, the Army is also exploring ways to apply the revised entry and exit criteria to Reserve and National Guard servicemembers and is planning to issue a corresponding policy in March 2009.

The Army's revised WTU entry criteria for active component servicemembers are intended to help ensure that only those who need complex case management are placed in the WTU. For example, according to the original criteria, a servicemember was eligible for placement in a WTU if he or she had complex medical needs requiring more than 6 months of treatment and did not include an assessment of the servicemember's ability to perform his or her duties. The revised criteria state that an active component servicemember is eligible for placement in a WTU if he or she has complex medical conditions that require case management and will not be able to train for or contribute to the mission of a unit for more than 6 months.

The WTU exit criteria, which had not been explicitly articulated in the original WTU policy, now allow local leadership greater flexibility in reassigning active component servicemembers to other units on the installation. Previously, an active component servicemember would remain in a WTU until he or she was able to return to duty and completed his or her medical treatment or was discharged from the Army, even if the servicemember's medical care could be managed outside a WTU. The exit criteria state that an active component servicemember who is expected to return to duty may be reassigned to a unit on the installation before being found medically fit to return to duty if certain conditions are met. In particular, the servicemember may be reassigned if the servicemember's remaining medical needs can be managed outside a WTU and if the servicemember's reassignment has been approved by the Triad of Care and by leadership of the WTU, MTF, and installation.

Along with its policies establishing the revised entry and exit criteria, the Army required the Warrior Care and Transition Office to assess the effectiveness of the revised entry and exit criteria in ensuring that only those servicemembers needing complex case management are in the WTUs and to monitor the effects of the revised criteria. Specifically, the Warrior Care and Transition Office was tasked with developing measures for assessing the criteria's effectiveness. According to Army officials, the Warrior Care and Transition Office has not developed any additional measures to determine the effectiveness of the revised entry and exit criteria, but instead is relying on existing measures. For example, the number of servicemembers in WTUs decreased after implementation of the criteria, as the Army anticipated. Specifically, Army data show that the active component population of the WTUs has declined each month since the new entry and exit criteria went into effect, from about 8,400 in July 2008 to about 6,900 in November 2008.[15] Army officials also said that length of stay can be used to assess the entry and exit criteria because servicemembers requiring complex care would be expected to have longer lengths of stay in the WTU.

The policy with the revised entry and exit criteria also includes a provision for the Army Inspector General to assess the criteria as part of a broader provision to conduct a follow-up inspection of the Army's disability evaluation process and WTUs. An official within the Army's Office of the Inspector General told us that this inspection is included in its proposed long-range inspection plan for fiscal years 2009 and 2010, which is pending approval by the Secretary of the Army.

[15]These data include servicemembers at all WTUs, including WTUs in Germany and community-based WTUs.

The Army Uses Various Mechanisms to Monitor WTU Servicemembers' Recovery, but Its Feedback Mechanisms May Not Provide Complete Information

To monitor the recovery process of WTU servicemembers, the Army uses individual transition plans and various upward feedback mechanisms, but its feedback mechanisms may not provide complete information on the performance of WTUs. The Army's feedback mechanisms, which include a telephone hotline and a satisfaction survey, provide a way for servicemembers and their families to raise concerns about WTU-related issues. However, while this may provide helpful and important information to Army leadership, the concerns raised through these mechanisms are not necessarily representative of the concerns of all WTU servicemembers and their families.

The Army Is Implementing Plans for Monitoring the Recovery of Individual Servicemembers

To facilitate servicemembers' recovery, the Army has developed a process for coordinating and monitoring the care that servicemembers receive while in a WTU. In January 2008, the Army issued a policy establishing Comprehensive Transition Plans for WTU servicemembers.[16] A plan includes a servicemember's medical conditions and vocational training needs, as well as his or her expectations and goals for the recovery process. The Army requires that a servicemember's transition plan be developed within 30 days of his or her placement into the WTU by WTU leadership and Triad of Care staff with input from the servicemember and his or her family. The WTU and MTF commanders are responsible for ensuring that the transition plan is developed.

Army policy requires that the Triad of Care monitor the servicemember's transition plan weekly. For example, officials told us that meetings, which may include staff in addition to the Triad of Care, are held to determine whether the goals documented in the servicemember's transition plan are being met and to modify the plan as necessary. Additionally, according to an Army official, conducting periodic formal evaluations of the transition plan is required to determine whether the servicemember should (1) return to duty, (2) continue rehabilitation, or (3) be referred to the Army disability evaluation process. An official said that these formal evaluations occur at least every 3 months, but can occur more often based on the servicemember's transition plan.

[16]Comprehensive Transition Plans were initially referred to as Comprehensive Care Plans.

In addition to actions already underway, the Army is developing additional policy to assist WTUs in developing the Comprehensive Transition Plans, which could help ensure that the plans are implemented consistently across WTUs and that the transition needs of all servicemembers in the WTUs are regularly assessed. According to the Army, this additional policy will include guidance on setting goals with servicemembers and their families. It will also include performance measures that will allow the Army to more systematically monitor the extent to which WTUs have developed transition plans for its servicemembers. For example, according to the Army, the performance measures will include the number of servicemembers in WTUs for more than 30 days who do not have a transition plan. The policy will require that the performance measures be reported at least monthly. During a 6-month period over the course of our review, Army officials had provided us with various dates for which they had expected that this policy would be finalized, but this had not yet occurred as of February 27, 2009.

Related to one of these performance measures, the Army has begun reporting data on the number of servicemembers in WTUs for more than 30 days who had a transition plan. Our analysis of these data shows that as of January 6, 2009, 94 percent of all servicemembers in WTUs across the United States had transition plans. Specifically, between 84 and 100 percent of servicemembers at 32 of 33 WTUs had transition plans. At the remaining WTU, 73 percent of servicemembers had transition plans. Officials from this WTU said that, because of the rapid growth in the WTU servicemember population, there were insufficient staff in some positions involved in developing the transition plan, such as social workers. As a result, officials were first developing transition plans for servicemembers who had the greatest need. Additionally, officials said that some servicemembers did not need transition plans because they were in the process of leaving the WTU.

The Army Obtains Information on Servicemembers' Concerns through Various Upward Feedback Mechanisms, but This Information May Not Be Representative of All WTU Servicemembers

Using various upward feedback mechanisms, the Army has obtained information about different aspects of its WTUs, including the Triad of Care. (See table 1.) For example, the Army requires each of its WTUs to hold monthly Town Hall meetings to serve as a forum for WTU servicemembers and their family members to voice their concerns directly to WTU and installation leadership. Additionally, after the media reported deficiencies at Walter Reed Army Medical Center, the Army established two other feedback mechanisms—the Wounded Soldier and Family Hotline and the Ombudsman Program—which are also available to servicemembers receiving care at the MTF who are not part of the WTU

and their families. Through both of these mechanisms, Army personnel are available to address servicemembers' concerns about medical and nonmedical issues, including transportation, financial, legal, and housing concerns. The Army collects and analyzes data from these feedback mechanisms to identify trends and potential problem areas. While this may provide helpful and important information to Army leadership about the performance of the WTUs, the concerns raised through these mechanisms are not necessarily representative of all concerns of WTU servicemembers and their families because they are dependent upon the initiative taken by individuals and because they may include concerns from servicemembers not in WTUs.

Table 1: Selected Army-wide Upward Feedback Mechanisms

Monitoring type	Date established	Description
Town Hall Meeting	June 2007	Provides a venue for servicemembers and their families to ask questions and raise concerns to WTU leadership. The Army requires each WTU to conduct these meetings monthly.
Wounded Soldier and Family Hotline	March 2007	Offers wounded and injured servicemembers and their families a way to elevate medical and nonmedical issues, which are forwarded to the appropriate Army officials for resolution. As of November 30, 2008, the hotline had received 16,724 calls.
Ombudsman Program	April 2007	Places soldier and family advocates at Army MTFs. They are available to assist servicemembers and their families with both medical and nonmedical issues by serving as a liaison to the Army's Medical Command and the MTF.[a] As of November 30, 2008, the Army had a total of 56 ombudsmen. For the period January 2008 through November 2008, 1,130 issues related to the WTUs or case management services were reported to ombudsmen.
Warrior Transition Unit Program Satisfaction Survey	June 2007[b]	Surveys WTU servicemembers to determine satisfaction with their primary care manager and nurse case manager, access to medical care, and other medical and nonmedical issues. The survey is administered to servicemembers on certain anniversary dates—30, 120, 280, and 410 days after entry in the WTU.

Source: GAO based on review of Army documentation and interviews with Army officials.

[a]The Army does not have an ombudsman at Fort Leavenworth, KS; Fort Meade, MD; Fort Rucker, AL; or Redstone Arsenal, AL. An ombudsman at the nearest MTF supports these locations.

[b]Prior to June 2007, the Army implemented this survey under a different name for National Guard and Reserve servicemembers. In June 2007, the Army expanded the population surveyed to include active component servicemembers, added questions about the WTUs, and changed the name of the survey.

In addition, the Army obtains feedback on WTUs through its Warrior Transition Unit Program Satisfaction Survey, which solicits feedback on the performance of WTUs, including the WTUs in Germany and the community-based WTUs. This survey is designed to assess servicemembers' satisfaction with various aspects of WTUs, including the

primary care manager and nurse case manager.[17] The Army began administering this survey in June 2007 to servicemembers who had been placed in WTUs. The Army mails the survey to WTU servicemembers on the 30-, 120-, 280-, and 410-day anniversaries of their placement into the WTU. In February 2008, the Army began following up by telephone with servicemembers who did not respond 30 days after the surveys were mailed.

Although the Army has used this survey to report relatively high satisfaction rates among WTU servicemembers, including servicemembers at WTUs in Germany and community-based WTUs, the survey results may not be representative of all WTU servicemembers. During the period July 2007 through September 2008, the Army's data showed that for WTUs at military installations, the percentage of servicemembers satisfied ranged between approximately 60 and 80 percent, and for the community-based WTUs, between approximately 80 and 90 percent. However, the overall monthly response rates for WTU respondents ranged between 13 and 35 percent for the period June 2007 through September 2008, which was the most current data available at the time of our review. Such a low response rate decreases the likelihood that the survey results accurately reflect the views and characteristics of the target population.

Despite low response rates, the Army has not conducted additional analyses to determine whether its survey results are representative of the entire WTU servicemember population. According to Office of Management and Budget guidelines, best practices to ensure that survey results are representative of the target population include conducting a nonresponse analysis for surveys with a response rate lower than 80 percent.[18] Although the Army was not required to seek the Office of

[17]In general, agency surveys must be approved by the Office of Management and Budget. See 44 U.S.C. § 3507. However, DOD has authority to conduct surveys of servicemembers and their families to determine the effectiveness of federal programs relating to military families and the need for new programs without seeking approval from the Office of Management and Budget. See 10 U.S.C. § 1782; DOD 8910.1-M, *Department of Defense Procedures for Management of Information Requirements* § C3.7 (June 1998). Accordingly, the Army did not seek Office of Management and Budget approval for the Warrior Transition Unit Program Satisfaction Survey.

[18]See *Office of Management and Budget Standards and Guidelines for Statistical Surveys (September 2006)*, which documents the professional principles and practices that federal agencies are required to adhere to and the level of quality and effort expected in statistical activities. For questionnaire surveys, regardless of the mode of administration—mail or telephone—a nonresponse analysis may be conducted by randomly selecting a sample of the nonrespondents and surveying them to obtain answers to key survey questions.

Management and Budget's approval for the Warrior Transition Unit Program Satisfaction Survey, these are generally accepted best practices and are relevant for the purposes of assessing whether the survey results are representative of all WTU servicemembers. A nonresponse analysis may be completed on more than one occasion, depending on how frequently the survey is administered. A nonresponse analysis can be used to determine if the responses from nonresponding servicemembers would be the same as the responses from responding servicemembers. Therefore, this analysis could help the Army determine whether its WTU satisfaction survey results are representative of all WTU servicemembers. An Army official told us that the Army does not plan to conduct nonresponse analyses because it is satisfied with the response rates that it has been receiving since it began following up with servicemembers by telephone in February 2008. For the period February 2008 through September 2008, WTU response rates for both mail and telephone respondents, including WTUs in Germany and community-based WTUs, have ranged between 26 and 35 percent. In addition, this official told us that beginning in Spring 2009 the Army no longer plans to conduct this survey by mail, but will conduct this survey solely by telephone, and expects response rates to further increase once this occurs.

Nonetheless, the Army has used its survey results to monitor trends and identify areas for improvement. For example, the Army conducted additional analyses of nine WTUs, which are among the largest WTUs. For one of these WTUs, the Army reported that additional analyses indicated that factors contributing to low satisfaction included decreased satisfaction about pain control and financial issues. The analyses also showed that servicemembers in this WTU for more than 280 days were the most dissatisfied.

While Army leadership may use the Warrior Transition Unit Program Satisfaction Survey results to identify areas for improvement, Army officials at some locations we visited said that low response rates and lack of specific information limits the usefulness of the survey at the local level. Consequently, some WTUs have undertaken local efforts to collect information about servicemembers' satisfaction. Army officials at three of the WTUs we visited told us that they have independently conducted local satisfaction surveys to obtain specific information from their servicemembers. These local efforts have focused on gauging satisfaction in several areas, including, for example, satisfaction with nurse case managers, primary care managers, and squad leaders. The local surveys do not replace the Army-wide satisfaction survey, and Army officials reported that they have been able to use them to improve services at individual

WTUs. For example, at one location we visited, officials administered a satisfaction survey in January 2008 and August 2008 that focused on the nurse case managers. These results showed that, while servicemembers were generally satisfied with their nurse case managers, a few servicemembers commented that their nurse case manager's caseload was too large. In response to the survey results, the WTU has worked to balance the caseload among the nurse case managers so that no case manager has an excessive number of WTU servicemembers.

Conclusions

After problems at Walter Reed Army Medical Center were disclosed in early 2007, the Army dedicated significant resources and attention to improving outpatient care for servicemembers through the establishment of the WTUs. Initially, the Army faced challenges fully staffing the units to serve an increasing population, but revisions to WTU policies substantially reduced staffing shortfalls and appeared to manage population growth for active component servicemembers. As of January 2009, almost all of the Triad of Care positions in the WTUs were fully staffed. In addition, the number of active component servicemembers in WTUs decreased within the first 4 months of implementing the revised entry and exit criteria. Sustained attention to staffing levels and the implementation of the revised WTU entry and exit criteria will be important for maintaining these gains and helping to ensure that servicemembers are getting the care that they need.

The Army demonstrated its dedication to caring for its WTU servicemembers by studying and revising its staffing model, including staff-to-servicemember ratios for selected positions, to help ensure the WTUs were providing an appropriate level of care. However, a lingering concern—in light of the study's findings not applying to the WTU at Walter Reed Army Medical Center—is that the Army does not have a plan to conduct a similar study for this WTU. The population receiving care at Walter Reed has more complex health care needs than the population at other WTUs, and might also require, for example, higher staff-to-servicemember ratios. Without an assessment of the current staffing model that considers this complexity, the Army cannot be assured that it is providing an appropriate level of care to servicemembers at Walter Reed. This evaluation could help the Army determine the appropriate staffing model for the population at Walter Reed and ensure that previously reported problems with coordination of care and treatment for this population do not recur. Furthermore, an assessment of Walter Reed's staffing model could help the Army make staffing decisions in preparation

for the transfer of seriously injured servicemembers to other facilities once Walter Reed closes in 2011.

Continued monitoring of the Army's WTUs, including servicemembers' recovery process, will be important for ensuring that these units are meeting servicemembers' needs. The Army's Comprehensive Transition Plans appear to be a significant step towards ensuring that servicemembers are receiving the care they need by regularly assessing their progress. However, the Army has not finalized policy that would allow it to systematically determine whether WTUs are consistently developing these plans. The Army has also established various upward feedback mechanisms that help inform Army leadership about issues WTU servicemembers are facing, but they do not provide information on the overall effectiveness of the WTUs. The Army's Warrior Transition Unit Program Satisfaction Survey could potentially be used to collect information representative of the WTU population. However, the survey has had low response rates, and the Army has not performed additional analysis to determine whether these results are representative of all WTU servicemembers. Although the Army's plan to conduct the satisfaction survey solely by telephone may increase response rates, nonresponse analyses may still be warranted because the response rates may remain well below 80 percent—the level where generally accepted best practices call for nonresponse analyses to ensure that survey results are representative. Without representative information, the Army cannot reliably report servicemembers' satisfaction with the WTUs, and without such data Army officials could potentially be unaware of serious deficiencies like those that were identified at Walter Reed in 2007.

Recommendations for Executive Action

We recommend that the Secretary of Defense direct the Secretary of the Army to take the following three actions:

- To help ensure that the WTU at Walter Reed Army Medical Center is providing an appropriate level of care to servicemembers and help the Army make future staffing decisions for the WTUs that will be caring for this population once Walter Reed closes, the Army should examine Walter Reed's WTU staffing model, including its Triad of Care staff-to-servicemember ratios, in light of the complexity of the health care needs of servicemembers placed in this WTU.

- To help ensure that the Comprehensive Transition Plans are implemented consistently across WTUs and that the Army has performance data for monitoring the implementation of the transition plans, the Army should

expedite efforts to finalize and implement its policy for guiding the development of the Comprehensive Transition Plans.

- To determine whether the results of the Warrior Transition Unit Program Satisfaction Survey can be used to assess the effectiveness of the WTUs, the Army should take steps to determine whether the results are representative of all servicemembers in WTUs, such as by conducting nonresponse analyses, and should take additional steps if necessary to obtain results that are representative.

Agency Comments and Our Evaluation

In commenting on a draft of this report, DOD stated that it concurred with our findings and recommendations. (DOD's comments are reprinted in appendix II.) However, DOD's description of the actions that it has taken and those that it plans to take to respond to the recommendations did not fully address two of the recommendations.

- In response to our recommendation to examine the WTU staffing model at Walter Reed Army Medical Center, DOD indicated that the Army has multiple planning efforts and studies underway to prepare for the closing of Walter Reed. For example, it indicated that the Center for Army Analysis is determining the capacity and capabilities of Fort Meade, Fort Belvoir, and the new Walter Reed National Military Medical Center to determine how best to provide the appropriate level of care and services to these WTU servicemembers. DOD also indicated that Walter Reed has sufficient resources to provide appropriate care until the new Walter Reed is completed. Specifically, DOD commented that Walter Reed's staffing has met or in certain areas exceeded that of other WTUs—for example, nurse case managers have dedicated supervisory assistance available to them at all times and the Walter Reed nurse case manager staff-to-servicemember ratio is 1:18, compared to 1:20 at other WTUs. In describing the Army's efforts and studies, however, DOD did not indicate how, if at all, they would be examining the WTU staffing model at Walter Reed, including the Triad of Care staff-to-servicemember ratios. Furthermore, although Walter Reed may have additional resources and its nurse case managers may operate under a slightly higher ratio, the population receiving care at Walter Reed has more complex health care needs than the population at other WTUs. We continue to believe that without an assessment of the current staffing model that considers this complexity, the Army cannot be assured that it is providing an appropriate level of care to servicemembers at Walter Reed. Furthermore, we continue to believe that such an assessment can help the Army make future staffing decisions for the WTUs that will be caring for this WTU population once Walter Reed closes. As such, it is imperative that DOD take all actions necessary to examine the WTU staffing model at Walter Reed.

- With respect to our recommendation for the Army to take steps to determine whether the results of the Warrior Transition Unit Program Satisfaction Survey are representative of all servicemembers in WTUs, DOD's response does not indicate that the Army will be taking the actions that we recommended. DOD indicated that the Army's change to telephone surveys has greatly increased response rates and a nonresponse analysis is currently not required. However, DOD did not indicate its most recent response rates. Although DOD indicated that the Army would reevaluate the need for a nonresponse analysis by September 1, 2009, unless the change to telephone surveys has resulted in a response rate that is 80 percent or higher, we believe that taking steps to determine whether the results are representative of all servicemembers in WTUs is warranted. Without such data, we continue to believe that the Army cannot reliably report servicemembers' satisfaction with the WTUs and that Army leadership could potentially be unaware of serious deficiencies in some of its WTUs.

With regard to our recommendation for the Army to finalize and implement its policy for guiding the development of Comprehensive Transition Plans, DOD responded that the policy was signed on March 10, 2009. DOD also indicated that staff associated with the Army's Organizational Inspection Program are assisting with the implementation of the plans and will validate compliance with the new policy.

We are sending copies of this report to the Secretary of Defense, relevant congressional committees, and other interested parties. The report also is available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix III.

Randall B. Williamson
Director, Health Care

List of Requesters

The Honorable Steve Buyer
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable John Hall
Chairman
Subcommittee on Disability Assistance
and Memorial Affairs
Committee on Veterans' Affairs
House of Representatives

The Honorable Harry Mitchell
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable John F. Tierney
Chairman
Subcommittee on National Security and Foreign Affairs
Committee on Oversight and Government Reform
House of Representatives

The Honorable Kirsten Gillibrand
United States Senate

The Honorable Jason Altmire
House of Representatives

The Honorable Michael Arcuri
House of Representatives

The Honorable Bruce Braley
House of Representatives

The Honorable Christopher Carney
House of Representatives

The Honorable Kathy Castor
House of Representatives

The Honorable Yvette Clarke
House of Representatives

The Honorable Steve Cohen
House of Representatives

The Honorable Joe Courtney
House of Representatives

The Honorable Joe Donnelly
House of Representatives

The Honorable Keith Ellison
House of Representatives

The Honorable Brad Ellsworth
House of Representatives

The Honorable Gabrielle Giffords
House of Representatives

The Honorable Phil Hare
House of Representatives

The Honorable Baron Hill
House of Representatives

The Honorable Mazie Hirono
House of Representatives

The Honorable Paul Hodes
House of Representatives

The Honorable Hank Johnson
House of Representatives

The Honorable Steve Kagen, M.D.
House of Representatives

The Honorable Ron Klein
House of Representatives

The Honorable David Loebsack
House of Representatives

The Honorable Jerry McNerney
House of Representatives

The Honorable Chris Murphy
House of Representatives

The Honorable Patrick J. Murphy
House of Representatives

The Honorable Ed Perlmutter
House of Representatives

The Honorable Ciro D. Rodriguez
House of Representatives

The Honorable John Sarbanes
House of Representatives

The Honorable Joe Sestak
House of Representatives

The Honorable Carol Shea-Porter
House of Representatives

The Honorable Heath Shuler
House of Representatives

The Honorable Albio Sires
House of Representatives

The Honorable Zach Space
House of Representatives

The Honorable Betty Sutton
House of Representatives

The Honorable Timothy Walz
House of Representatives

The Honorable Peter Welch
House of Representatives

The Honorable Charles Wilson
House of Representatives

The Honorable John Yarmuth
House of Representatives

Appendix I: Scope and Methodology

Overall, to evaluate the Army's efforts to staff and monitor its Warrior Transition Units (WTU), we obtained documentation from and interviewed officials with the Army's Office of the Surgeon General, Medical Command, Warrior Care and Transition Office, Manpower Analysis Agency, and Office of the Inspector General. To gain an understanding of staffing and monitoring activities at individual WTUs, we visited five WTU locations—Forts Benning and Gordon (Georgia), Fort Lewis (Washington), Fort Sam Houston (Texas), and Walter Reed Army Medical Center (Washington, D.C.). We selected these locations because they represent different Army regional Medical Commands and they vary in the number of servicemembers placed in the WTU. Because we did not visit a representative sample of WTUs, the results from these visits cannot be generalized to other WTUs. At each location, we met with WTU command staff, nurse case managers or primary care managers, and servicemembers placed in the WTU to gain their perspectives on case management services being provided through the WTU. We also met with officials representing the Army's regional Medical Command to discuss case management services, including staffing and monitoring.[1] Lastly, we met with officials representing the Case Management Society of America to obtain their perspectives on the Army's WTUs and efforts to monitor healthcare provided to servicemembers.

More specifically, to assess the Army's ongoing efforts to staff its WTU Triad of Care positions—primary care managers, nurse case managers, and squad leaders—we obtained and reviewed the Army Warrior Care & Transition Program,[2] which established policies for implementing the WTUs. We also reviewed additional staffing policies that the Army established in July 2008. These policies included additional requirements for staffing the WTUs and a new WTU staffing model that included revised WTU staff-to-servicemember ratios. To determine the extent to which the Army was meeting its staff-to-servicemember ratios for its Triad of Care positions, we analyzed Army staffing and servicemember population data for the 33 WTUs that were established at MTFs located at Army installations within the United States. We did not verify the accuracy of these data. We did, however, speak with Army officials regarding the reliability of the data and determined them to be sufficiently reliable for

[1]The Army regional Medical Commands are located in six geographic locations, including the United States, Europe, and the Pacific. These commands oversee the daily operations of the military treatment facilities (MTF) within their respective regions.

[2]This plan was previously called the Army Medical Action Plan.

the purposes of our review. We also did not evaluate the appropriateness of the Triad of Care ratios for meeting the staffing needs of the WTUs.

To determine how the Army is monitoring the recovery process of servicemembers in WTUs, we reviewed the Army's policy and guidance regarding the implementation of its Comprehensive Transition Plans. We also spoke with an Army official about a draft policy related to the documentation of the transition plans that would include performance measures to track compliance. To determine the extent to which the 33 WTUs within the United States had plans for individual servicemembers, we analyzed the Army's biweekly data on the number of servicemembers who had been in the WTU for at least 30 days who had a transition plan. We did not verify the accuracy of these data. We did, however, speak with an Army official regarding the reliability of the data and determined them to be sufficiently reliable for the purposes of our review. We also reviewed protocols and procedures for selected upward feedback mechanisms. The Army uses a number of mechanisms for obtaining feedback from servicemembers and their families to address WTU-related issues, but we did not review every mechanism. We focused on the Town Hall Meeting, Wounded Soldier and Family Hotline, the Ombudsman Program, and the Warrior Transition Unit Program Satisfaction Survey. We focused on these mechanisms because they were implemented shortly after the media reported deficiencies at Walter Reed Army Medical Center and because they provide WTU servicemembers and their families with methods for sharing their experiences and concerns about health care and case management with Army leadership. For the Army's Warrior Transition Unit Program Satisfaction Survey, which is used to assess servicemembers' satisfaction across all WTUs, we reviewed the survey questionnaire, protocol, and results for the period July 2007 through September 2008, which were the most recent data available at the time of our review. We reviewed and analyzed Army data on the number of surveys mailed monthly and corresponding response rates for all of the WTUs, including the overseas and community-based WTUs. We assessed the reliability of these data by reviewing related documentation and speaking with knowledgeable agency officials and determined the data to be sufficiently reliable for our purposes. We also reviewed the *Office of Management and Budget Standards and Guidelines for Statistical Surveys (September 2006)* to identify standards for statistical surveys conducted by federal agencies, including best practices for ensuring that survey results are representative of the target population. Although the Army is not required to seek Office of Management and Budget approval to conduct its satisfaction survey, these guidelines are relevant for assessing whether survey results are representative. Lastly, three WTUs we visited

administered local surveys and we obtained and reviewed their survey questionnaires and corresponding results, when available. However, we did not review the survey methodology for those WTUs that administered a local survey. Further, because these local surveys collected data that were specific to these WTUs, the survey results cannot be generalized to all WTUs.

We conducted this performance audit from June 2007 to April 2009, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 27 2009

Mr. Randall B. Williamson
Director, Health Care
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

Dear Mr. Williamson:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report, GAO-09-357, "ARMY HEALTH CARE: Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed," dated February 27, 2009 (GAO Code 290635)."

Thank you for the opportunity to review and comment on the draft report. Overall, I concur with the report's findings and conclusions. Responses to the draft report's recommendations are attached. Since the recommendations specifically concerned the Army and the health care provided to wounded warriors, they were provided to the Office of the Army Surgeon General for review and development of responses. My staff and the Army functional points of contact worked collegially to develop the responses which have been approved by the Army Surgeon General.

Again, thank you for the opportunity to provide these comments. My points of contact for additional information are Lieutenant Colonel Glenda Mitchell (Functional) at (703) 681-6717, glenda.mitchell@tma.osd.mil and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-4360, gunther.zimmerman@tma.osd.mil.

Sincerely,

S. Ward Casscells, M.D.

Enclosures:
As stated

GAO DRAFT REPORT – DATED February 27, 2009
GAO CODE 290635/GAO-09-357

ARMY HEALTH CARE: Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed.

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATIONS

RECOMMENDATION 1: The GAO recommends that the Secretary of Defense direct the Secretary of the Army to examine Walter Reed's Warrior Transition Unit (WTU) staffing model, including its Triad of Care staff-to-Service member ratios, in light of the complexity of the health care needs of Service members placed in this WTU to help ensure that the WTU at Walter Reed Army Medical Center is providing an appropriate level of care to Service members and help the Army make future staffing decisions for the WTUs that will be caring for this population once Walter Reed closes.

DOD RESPONSE: Concur. Multiple planning efforts or studies are underway in order to prepare for the eventual closing of Walter Reed Army Medical Center (WRAMC). Among these, the Center for Army Analysis is determining the capacity and capabilities of Fort Meade, Fort Belvoir and the new Walter Reed to determine how best to provide the appropriate level of care and services to these Warriors in Transition. This study should be completed by June 30, 2009. In conjunction with this study, the Warrior Care and Transition Office and the North Atlantic Regional Medical Command are in the process of planning how to best provide the appropriate level of care and services to soldiers in the National Capital Region. Additionally, the Army Medical Command monitors the access to care standards at Walter Reed, as well as every other Warrior Transition Unit, to determine the appropriate level of care is given to each Warrior in Transition. The Wounded Warrior Act of 2008 required that WRAMC remain resourced sufficiently to provide appropriate care until the new Walter Reed Military National Medical Center is completed. This is being accomplished. Since the inception of the Warrior Transition Unit (WTU) concept, staffing at the WRAMC unit has met or in certain areas exceeded that of other WTUs. This is seen in the establishment of this unit as a Brigade element with a Colonel as Commander, to include the same or greater care and command and control support than, for example, exists at the Company size WTU level. As a result, the Nurse Case Managers (assigned at a lower Nurse Case Manager to Warrior in Transition ratio of 1:18 than the 1:20 ratio of other WTUs) and other medical and care professionals have dedicated supervisory assistance available to them at all times. Additionally, the WRAMC WTU also has the support of a dedicated Warrior Transition Unit of providers focused entirely on Warrior in Transition care, and the Military Advanced Training Center (MATC), a state-of-the-art therapy and rehabilitation center equipped with state of the art capabilities and a dedicated staff of therapists and other professionals totally focused on the rehabilitation of Warriors in Transition. These additional resources over and above those of other WTUs, coupled with the demonstrated

excellence and satisfaction found in the care received at this premier medical center is considered indicative that the care and treatment model currently in use is appropriate and effective. The OSD Transition Policy and Care Coordination (TPCC) Office has recommended the Army consider adding at least one Recovery Care Coordinator (RCCs) to the WTU at WRAMC. The Army RCCs are currently placed under the AW2 program to assist recovering service members who meet that program criteria. In discussions with Army leadership, the TPCC Director recommended the Army consider either expanding the scope of the AW2 program criteria or placing RCCs in the WTUs, in order to better serve the Army population of recovering service members who do not meet the AW2 program criteria. The Army is considering this recommendation.

RECOMMENDATION 2: The GAO recommends that the Secretary of Defense direct the Secretary of the Army to expedite efforts to finalize and implement its policy for guiding the development of the Comprehensive Transition Plans to help ensure that the Comprehensive Transition Plans are implemented consistently across WTUs and that the Army has performance data for monitoring the implementation of the transition plans.

DOD RESPONSE: Concur. The Comprehensive Transition Policy (CTP) was signed on March 10, 2009 by Lieutenant General Eric B. Schoomaker, M.D., PhD, The Surgeon General of the United States Army and Commander, U.S. Army Medical Command. Currently, the CTP annexes and working documents along with the goal setting training is on the Warrior in Transition Program website for Warrior in Transition Unit Commanders to utilize. The Organizational Inspection Program (OIP) includes measurable tasks and standards which support the CTP. In addition, the Subject Matter Experts on the OIP Team conduct staff assistance regarding CTP implementation. The OIPs will validate compliance with policy as set forth in the CTP until more aggressive implementation and training can be conducted. The Warrior Care and Transition Office will publish draft doctrine for the CTP within 60 days of March 10, 2009. That draft will then go to the field for staffing and recommended improvements with a target date for approved doctrine of July 1, 2009. The OSD Transition Policy and Care Coordination Office (TPCC) Director has recommended to Army leadership that to comply with the NDAA 08 requirements for each recovering service member to have a Comprehensive Recovery Plan (CRP), the Army consider combining the requirements of the CRP into the Army CTP. Uniform standards have been developed and agreed to by the Services for the creation of a CRP. The Recovery Care Coordinators will assist in the development of the recovery plan and provide oversight of its implementation.

RECOMMENDATION 3: The GAO recommends that the Secretary of Defense direct the Secretary of the Army to take steps to determine whether the results are representative of all Service members in WTUs, such as by conducting nonresponse analyses, and take additional steps if necessary to obtain results that are representative to determine whether the results of the Warrior Transition Unit Program Satisfaction Survey can be used to assess the effectiveness of the WTUs.

DOD RESPONSE: Concur. The Army has numerous metrics that allow transparency into the Warrior Care and Transition Program. The use of independent surveys is one means by which the Army gains an indication of soldier satisfaction. Additionally, the Commander of the Walter Reed Warrior in Transition Unit conducts his own satisfaction survey, the results of which correlate well with those obtained using the Synovate instrument. Soldiers are satisfied with the program. As part of an ongoing effort to improve the quality of responses received to the Synovate instrument, the previous hard-copy survey was recently replaced by telephonic surveys. This has greatly increased the percentage of respondents, yet the overall satisfaction expressed in these surveys has not wavered. As the change to telephonic surveys has resulted in an increased response rate, we believe a nonresponse analysis is not required at this time. However, we will re-evaluate the need for a nonresponse analysis not later than September 1, 2009.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Janina Austin; Susannah Bloch; Christopher Langford; Lisa Motley; Jessica C. Smith; C. Jenna Sondhelm; and Suzanne Worth made major contributions to this report.

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